

DIRECTOR OF STAFF DEVELOPMENT/INSTRUCTOR APPLICATION

Type or print legibly.

Facility/school/agency telephone number ()	County	Provider Identification Training number ("S" or "F" number)
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Facility/school/agency name and address:

Type of training to be offered:

- ☐ Orientation and in-service training programs only
☐ Certification training program only
☐ Orientation, in-service, and certification training programs

Applicant's name	<input type="checkbox"/> RN <input type="checkbox"/> LVN	California Nursing license number	Expiration date
Hours employed _____ per week / _____ per month	Date employed as DSD/Instructor	Facility licensed bed capacity (if applicable)	Date submitted to DHS
Applicant signature			Date

- Please submit:
1. Resumé showing work experience (month/year to month/year).
 2. Proof of 24-hour BRN-approved DSD class or transcript of college courses related to teaching.

Facility/School/Agency or Employment Information

Name			Telephone number ()
Address (number, street)	City	County	ZIP code
Administrator/Program Director signature and title	Print name	Date	
Director of Nursing signature _____, R.N.	Print name	Date	

FOR OFFICE USE ONLY

Approved	Date	By: Program consultant
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